

**Cohen Student Health Center  
Mercyhurst University  
501 East 38th Street  
Erie, Pennsylvania 16546  
814-824-2431  
FAX: 814-347-8275**

**INSTRUCTIONS FOR ALLERGY SERUM ADMINISTRATION**

Your patient has requested to continue with receiving their allergy serum at the Cohen Student Health Center while attending Mercyhurst University. Injections are given according to their allergist's schedule and protocol. Please provide all of the necessary information on this form and mail or fax this document to Mercyhurst University's Cohen Student Health Center. Your patient will also be speaking with you concerning transporting their allergy serum to the university clinic.

PATIENT INFORMATION: (Please Print)

|       |                |
|-------|----------------|
| Name: | Date of Birth: |
|-------|----------------|

ALLERGY VACCINE ADMINISTRATION INFORMATION:

|                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| VACCINE SPECIFICS INCLUDING CONCENTRATION, DOSE & EXPIRATION DATE OF SERUM:<br>Expiration Date: _____<br>_____<br>_____<br>Storage Requirements: _____ |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|

SCHEDULE OF ADMINISTRATION:

|                     |
|---------------------|
| -<br>_____<br>_____ |
|---------------------|

INSTRUCTIONS FOR MISSED DOSES: (1,2,3,4 WEEKS LATE):

|                         |
|-------------------------|
| _____<br>_____<br>_____ |
|-------------------------|

ADMINISTRATION DURING ILLNESS:

Specific orders regarding administration of vaccine during acute illness? Febrile illness?

---

---

EMERGENCY INSTRUCTIONS FOR SEVERE REACTIONS:

---

---

---

ANY HISTORY OF SEVERE REACTIONS: **YES** **NO** (if you circle "yes", please provide details regarding date, vaccine, nature of reaction, and measures taken):

---

---

---

VACCINE RE-ORDER DATE: \_\_\_\_\_ DATE OF FOLLOW-UP APPT WITH ALLERGIST: \_\_\_\_\_

OTHER INFORMATION:

---

---

---

PHYSICIAN INFORMATION: (Please Print)

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Stamp: \_\_\_\_\_

Date: \_\_\_\_\_